IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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December 27, 2007

Donna Robinson
Mountain View Center for Geriatric Psychiatry
500 Polk Street East
Kimberly, Idaho 83341

RE: Mountain View Center for Geriatric Psychiatry, provider #134014

Dear Ms. Robinson:

Based on the survey completed at Mountain View Center for Geriatric Psychiatry on December 7, 2007 by our staff, we have determined that Mountain View Center for Geriatric Psychiatry is out of compliance with the Medicare Hospital Conditions of Participation on Quality Assessment/Performance Improvement (42 CFR 482.21). To participate as a provider of services in the Medicare Program, a Hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Mountain View Center for Geriatric Psychiatry to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **January 21, 2008.** **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than January 11, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134014	A. BUILDING _____ B. WING _____	C 12/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY	500 POLK STREET EAST KIMBERLY, ID 83341

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara. RN, HFS Acronyms used in this report include: DON = Director of Nursing QA = Quality Assurance QAPI = Quality Assessment/Performance Improvement	A 000		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263	A263 QAPI 482.21 QAPI Mountain View Center for Geriatric Psychiatry QAPI program plan, policy and monitor, schedule, and calendar on Quality Assessment and Performance Improvement (QAPI) program have been reviewed, revised and modified to define a hospital-wide continuous quality assessment program which focuses on the objective and systematic monitoring and evaluations of the quality and appropriateness of patient care efforts to improve patient care and identification and resolution of patient care problems. The QAPI plan and policy includes a description of the QAPI organization and its method of operation including its accountability to the medical staff, administrator, and governing body.	1/11/08

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Robinson	Administrator	1/11/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 263	Continued From page 1 This CONDITION is not met as evidenced by: Based on review of hospital policies and meeting minutes, and staff interview, it was determined the hospital failed to develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. In addition, the hospital's governing body failed to ensure that the program reflected the complexity of the hospital's organization and services and involved all hospital departments and services and focused on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital failed to ensure the QAPI program showed measurable improvement in quality indicators that would improve health outcomes (Refer to A265). The hospital failed to measure, analyze, and track quality indicators, including adverse patient events (Refer to A267). The hospital failed to use the quality data collected to monitor the effectiveness and safety of services and quality of care (Refer to A275). The hospital failed to specify the frequency and detail of data collection for the hospital's QAPI program (Refer to A277). The hospital failed to set priorities for its performance improvement activities that focused on high-risk, high-volume, or problem-prone areas (Refer to A285). The hospital failed to take actions aimed at performance improvement (Refer to A289). The hospital failed to conduct performance improvement projects (Refer to A297). The hospital failed to ensure the hospital's governing body, medical staff, and administrative officials were responsible and accountable for ensuring that QAPI program requirements were met (Refer	A 263	The revised QAPI plan and policy reflects the complexity of the hospital's organization and services; involves all the hospital departments and its services (provided directly or under arrangement); and focuses on indicators as it relates to improvement of health outcomes as evidenced by measureable improvements. In addition, the revised QAPI plan and policy measures, analyzes, and tracks quality indicators including adverse patients' events and utilizes the quality data collected to monitor the effectiveness and safety of services and quality of care rendered. The hospital QAPI plan and policy specifies the frequency and detail of data collection; sets priorities for its performance improvement activities that focus on high-risk, high volume, or problem-prone areas; takes additional action aimed at performance improvement; conducts performance improvement projects; prevents and reduces medication errors and ensures that the hospital's governing body, medical staff, and administrative officials are held accountable and responsible for ensuring that the QAPI program requirements are met. Through these adjustments and modifications, the hospital has the capability and capacity to evaluate and measure its processes and implement changes in order to improve patient care and reduce medical errors.	1/11/08

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A 263	Continued From page 2 to A309). The cumulative effect of these systemic problems resulted in the inability of the hospital to assess its processes and implement changes in order to improve patient care and reduce medical errors.	A 263		
A 265	482.21(a)(1) QAPI HEALTH OUTCOMES The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. This STANDARD is not met as evidenced by: Based on review of hospital policies, meeting minutes, quality improvement data, and staff interview, it was determined the hospital failed to ensure the QAPI program showed measurable improvement in quality indicators that would improve health outcomes. The findings include: 1. The only current policy defining the hospital's QAPI program was titled "Quality Assurance Committee". It had been updated 3/07. This policy superceded a policy titled "Improving Organizational Performance", revised 8/05. No other policies were in place, according to the QA Coordinator on 12/12/07 at 1:30 PM. The policy stated "Plans of correction and monitoring systems shall be designed by the Quality Assurance Committee with specific time frames to evaluate the corrections and initiate teaching programs or policy revisions to maximize the corrective process...A review of the status of any	A 265	A265 QAPI Health Outcomes 482.21(a)(1) Mountain View Center for Geriatric Psychiatry hospital policy on Quality Assessment and Performance Improvement (QAPI) program and QAPI policy have been reviewed, revised and modified to reflect a hospital-wide continuous quality assessment program which focuses on the objective and systematic monitoring and evaluations of the quality and appropriateness of patient care efforts to improve patient care and identification and resolution of patient care problems. The QAPI plan and policy includes a description of the QAPI organization and its method of operation including its accountability to the governing body. The newly revised QAPI plan and policy specifies how data will be gathered, analyzed, trended, and monitored over time. It also provides a guideline that will allow the hospital to examine and demonstrate measureable improvement by examining the data cohesively and more closely in order to determine which indicators prevented the hospital from achieving the QAPI goals and/or determining the need for any further action. Documentation on all QAPI meeting minutes will indicate and reflect individual tracking system to point out decline, improvements, identify possible causes for nor achieving QAPI goals, identify any plans to determine related problems and any changes made to ensure that indicators that have been identified have been corrected and plans of action are in place.	1/11/08

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A 265	Continued From page 3 plan of correction initiated shall be made at each committee meeting to determine acceptable corrective measures and/or the need for further action." The policy did not discuss how data would be gathered, analyzed, trended, and monitored over time. Finally, the policy stated "The quality assurance committee will be responsible for reviewing the Quality Assurance Plan at least annually..." A QA plan was not documented. The QA Coordinator and the Administrator stated the hospital did not have a QA plan, when interviewed together on 12/6/07 at 9:45 AM. 2. The hospital's QAPI program consisted of sets of indicators that were monitored but were not connected in a way that allowed the hospital to show measurable improvement. For example, the hospital conducted record reviews in relation to social services. Nine indicators looked at items including "Admission Paperwork Signed By Representative", "Behavior Care Plans (within) 24 Hrs. of Admission", "Weekly Treatment Team Summary Notes Completed", and others. These indicators were combined into a group titled "QTR SOCIAL SERVICE ADMISSION PAPERWORK". By averaging the total score of the indicators, the hospital arrived at a percentage for the category. The scores for QTR SOCIAL SERVICE ADMISSION PAPERWORK for the first 3 quarters of 2007 were 98%, 93%, and 92%, respectively. The goal for all categories was 95%. QAPI reports for 2007 showed the hospital did not examine the data more closely in order to determine which indicators prevented the hospital from achieving the QAPI goals. The data was not dissected in order to determine what the basic cause of the deficiency in the social service category was. The "QTR DIETARY SERVICES	A 265		

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A 265	Continued From page 4 REVIEW" category contained 3 items-initial assessment completed, dietician review, and dietary care plan initiated. The hospital combined the individual item scores and determined overall quarterly scores of 61%, 85%, and 73% respectively, for the first 3 quarters of 2007. These percentages were not broken down to determine which of the 3 items was causing the low scores, in order to address the problems. The "QTR PHYSICAL THERAPY REVIEW" category contained 6 items including orders, treatment plans, goals, progress and discharge notes. The hospital combined the individual item scores and determined overall quarterly scores of 63%, 63%, and 59% respectively, for the first 3 quarters of 2007. These percentages were not broken down in order to determine which of the 6 items was causing the low scores, in order to address the problems. The hospital's QAPI program had 15 categories with multiple items in each category. All of the categories contained aggregate scores which did not tell the hospital what the problems actually were. In addition, QAPI and other committee meeting minutes for 2007 did not document that changes had been made based on the data that had been gathered for the QAPI program. QA Committee meeting minutes were documented for 12/20/06, 1/24/07, 4/18/07, and 11/21/07. Minutes for the first 3 meetings stated "All areas are meeting the 95% threshold level except..." the areas that were deemed deficient such as physical therapy. No other data was referred to in the minutes. The 11/21/07 meeting minutes did not cite any data. They did document "Discussion/Goal and plan of action" but this was not connected to data and not specific. For example, the 12/20/06 minutes stated "Nursing	A 265		

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A 265	Continued From page 5 Discharge Process Review" was below the threshold. The discussion under nursing stated "More turnovers in the RN position. The hospital is (short staffed)." The nursing discharge process was not addressed. The 1/24/07 minutes stated "Dietary Services" was below the threshold. The discussion under dietary stated "Discussed ways to achieve better diabetic diets for our patients." Diabetic diets was not an indicator and the reason for the low threshold in dietary services was not clarified or addressed. The 4/18/07 minutes stated "Physical Therapy" was below the threshold. No documentation was present that physical therapy was discussed at the meeting. No data was reported on the 11/21/07 meeting minutes. Discussion of 8 perceived problems was documented but no data supported the issues as problematic. No plans specified the use of data in order to determine the problems had been corrected. 3. The QA Coordinator and the Administrator were interviewed together on 12/6/07 at 9:45 AM. They stated data was gathered based on individual indicators and then was included in the aggregate categories. They confirmed the individual items in the 15 categories were not tracked and plans of correction were not based on those individual indicators. They said they could not state an example of a corrective action that had been taken based on the data that had been gathered and could not cite individual indicators that had improved based on corrective actions that had been taken.	A 265		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that	A 267		

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A 267	Continued From page 6 assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on review of hospital policies, meeting minutes, quality improvement data, and staff interview, it was determined the hospital failed to measure, analyze, and track quality indicators, including adverse patient events. The findings include: While the hospital documented incidents such as falls, other incidents, and medication errors, the hospital's QAPI program did not track the data over time or analyze the data in order to determine systemic causes of incidents and prevent them from recurring. The hospital documented falls and other physical incidents involving patients through incident reports. However, the number of incidents was not documented as being reported at QA Committee meetings, Medical Executive Committee meetings, or Governing Body meetings during 2007. This prevented the hospital from knowing if the number of incidents was increasing or decreasing. The hospital had not tracked the incidents over time and had not analyzed the incidents in order to determine if there were common contributing factors. Medication errors were documented in a monthly report which was provided to the Medical Executive Committee and the Governing Body in 2007. Again, while these errors were documented and reported, there was no	A 267	A267 QAPI Quality Indictors 482.21 (a)(2) Mountain View Center for Geriatric Psychiatry QAPI plan, policy, monitors, and indicators have been reviewed, revised and modified to reflect a hospital-wide continuous quality assessment program which focuses on the objective and systematic monitoring and evaluations of the quality and appropriateness of patient care efforts to improve patient care and identification and resolution of patient care problems. The QAPI plan and policy includes a description of the QAPI organization and its method of operation including its accountability to the governing body. A new QAPI program has been developed to demonstrate how to measure, analyze, and track quality indicators, including adverse patient events. Documentation on all QAPI meeting minutes will include tracking the data over time as well as analyzing the data in order to determine systemic causes of incidents, and based on analysis of common contributing factors, prevent said incidences from recurring. Quality indicators will be discussed and documented during the following meetings: medical executive committee meetings and QAPI committee meetings.	1/11/08

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A 267	Continued From page 7 documentation of trending over time and no documentation of analysis of the data in order to determine if there were common contributing factors. The QA Coordinator and the Administrator were interviewed together on 12/6/07 at 9:45 AM. They stated incident reports were not analyzed, tracked, or trended over time. They said medication errors were not tracked, or trended over time.	A 267		
A 275	482.21(b)(2)(i) QAPI QUALITY OF CARE The hospital must use the data collected to monitor the effectiveness and safety of service and quality of care. This STANDARD is not met as evidenced by: Based on review of hospital policies, meeting minutes, quality improvement data, and staff interview, it was determined the hospital failed to use the quality data collected to monitor the effectiveness and safety of services and quality of care. The findings include: 1. The only current policy defining the hospital's QAPI program was titled "Quality Assurance Committee". It had been updated 3/07. The policy did not discuss how data would be used to monitor the effectiveness and safety of services and quality of care. 2. QA Committee meeting minutes were documented for 12/20/06, 1/24/07, 4/18/07, and	A 275	A275 QAPI Quality of Care 482.21(b)(2)(i) Mountain View Center for Geriatric Psychiatry policy on Quality Assessment and Performance Improvement (QAPI) program plan and QAPI policy have been reviewed, revised and modified to reflect a hospital-wide continuous quality assessment program which focuses on the objective and systematic monitoring and evaluations of the quality and appropriateness of patient care efforts to improve patient care and identification and resolution of patient care problems. The QAPI plan and policy includes a description of the QAPI organization and its method of operation including its accountability to the governing body. The QAPI plan and policy provides a guideline on how to monitor the effectiveness and safety of services and quality of care. Documentation on QAPI meeting minutes will include reports on how effective the plans of correction are.	1/11/08

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A 275	Continued From page 8 11/21/07. Minutes for the first 3 meetings stated "All areas are meeting the 95% threshold level except..." the areas that were deemed deficient such as physical therapy. No other data was referred to in the minutes. The 11/21/07 meeting minutes did not cite any data. The effectiveness and safety of services and quality of care was not specifically documented in any of the QA Committee meeting minutes. No reports of how effective plans of correction were based on data were present in the minutes. No plan of correction that included data was documented in the minutes. This was confirmed during an interview with the QA Coordinator and the Administrator together on 12/6/07 at 9:45 AM.	A 275		
A 277	482.21(b)(3) QAPI PROGRAM DATA FREQUENCY The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on review of hospital policies and meeting minutes, it was determined the hospital's governing body failed to specify the frequency and detail of data collection for the hospital's QAPI program. The findings include: The only current policy defining the hospital's QAPI program was titled "Quality Assurance Committee". It had been updated 3/07. The policy did not specify the frequency and detail of data collection for the hospital's QAPI program. Data frequency and detail was not documented in either Medical Executive Meeting minutes or	A 277	A277 QAPI Program Data Frequency 482.21(b)(3) The hospital's Governing Board has specified the frequency and detail of data collection for the hospital's QAPI program. The QAPI plan and policy have been updated 12/07 to reflect the frequency and detail of data collection. Data frequency and detail will be documented in the Medical Executive Meeting Minutes and/or the Governing Board Meeting Minutes.	1/11/08

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A 277	Continued From page 9 Governing Board Meeting minutes. This was confirmed during an interview with the QA Coordinator and the Administrator together on 12/6/07 at 9:45 AM.	A 277		
A 285	482.21(c)(1) QAPI PATIENT SAFETY The hospital must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect patient safety. This STANDARD is not met as evidenced by: Based on review of hospital policies and Meeting minutes, it was determined the hospital failed to set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas. The findings include: The only current policy defining the hospital's QAPI program was titled "Quality Assurance Committee". It had been updated 3/07. The policy did not define or address high-risk, high-volume, or problem-prone areas. QA Committee Meeting minutes, Medical Executive Meeting minutes, and Governing Board Meeting minutes for 12/20/06 through 11/21/07 did not define or address high-risk, high-volume, or problem-prone areas. This was confirmed during an interview with the QA Coordinator and the Administrator together on 12/6/07 at 9:45 AM.	A 285	A285 QAPI Patient Safety 482.21(c)(1) The hospital has updated the QAPI plan and policy in 12/07 to address high risk, high volume, and problem prone areas. QAPI Committee Minutes, Medical Executive Meeting Minutes, and Governing Board Meeting Minutes reflect the definition of high risk, high volume, and problem prone areas.	1/11/08
A 289	482.21(c)(3) QAPI IMPROVEMENT ACTIONS The hospital must take actions aimed at	A 289		

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A 289	Continued From page 10 performance improvement. This STANDARD is not met as evidenced by: Based on review of QA Committee meeting minutes and staff interview, it was determined the hospital failed to take actions aimed at performance improvement. The findings include: QA Committee meeting minutes for 12/20/06 through 11/21/07 did not document specific problems or specific action taken to correct those problems. None of the meeting minutes for the above time frames documented specific problems identified by the QAPI program. Nor did they document the effectiveness of actions taken. The meetings in December 2006 and January and April of 2007 documented general problems or noted things that were happening in the hospital. For example, QA Committee meeting minutes, dated 12/20/06, stated a policy for patient valuables and belongings had been developed. QA Committee meeting minutes, dated 1/24/07, stated the hospital was gathering information for a patient rights and HIPPA inservice. QA Committee meeting minutes, dated 4/18/07, stated the hospital had entered a new policy concerning "ordering labs". All of the above minutes discussed personnel issues. QA Committee meeting minutes, dated 11/21/07, contained more specific problems, for example, the need to obtain more information prior to admitting patients. However, no measurable data was included in the identified problem and no quality indicators were adopted in order to measure whether the corrective actions were	A 289	A289 QAPI Improvement Actions 482.21(c)(3) Newly revised QAPI program meeting minutes will include documentation of specific problems, measureable data, and specific action taken to correct identified problems. A follow-up of the action taken will be documented by adopting quality indicators in order to measure and determine effectiveness of actions taken and included in QAPI program meeting minutes.	1/11/08

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A 289	Continued From page 11 successful. The QA Coordinator and the Administrator were interviewed together on 12/6/07 at 9:45 AM. They said they could not state an example of a specific problem that had been identified based on data gathered by the QAPI program and could not cite individual indicators that had improved based on corrective actions that had been taken.	A 289		
A 297	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. This STANDARD is not met as evidenced by: Based on review of hospital policies, meeting minutes, and staff interview, it was determined the hospital failed to conduct performance improvement projects. The findings include: The only current policy defining the hospital's QAPI program was titled "Quality Assurance Committee". It had been updated 3/07. This policy superceded a policy titled "Improving Organizational Performance", revised 8/05. The policy did not address performance improvement projects. The QA Coordinator and the Administrator were interviewed together on 12/6/07 at 9:45 AM. They stated no performance improvement projects had been implemented or maintained in the year prior to the survey.	A 297	A297 QAPI Performance Improvement Projects 482.21(d) The hospital has developed ongoing performance improvement projects as reflected by the QAPI meeting minutes. Policies have been updated in 12/07 to address current performance improvement projects. Mountain View Center for Geriatric Psychiatry has developed a performance improvement project to study the effectiveness of injectable medications in the management and treatment of acute psychotic episodes. The objective of the study is to determine if the prevalence of patients requiring additional injectable medication is greater with one medication versus another medication.	1/11/08
A 309	482.21(e) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized	A 309		

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A 309	Continued From page 12 group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that specific QAPI program requirements are met. This STANDARD is not met as evidenced by: Based on review of hospital policies, meeting minutes, quality improvement data, and staff interview, it was determined the hospital failed to ensure the hospital's governing body, medical staff, and administrative officials were responsible and accountable for ensuring that QAPI program requirements were met. The findings include: 1. The policy "Quality Assurance Committee", updated 3/07, stated "The Quality Assurance Committee functions as an advisory committee to the Governing Board. The committee has the full authority of the Governing Board to implement the Quality Assurance Program, including but not limited to, the following tasks: * Identifying negative and positive outcomes on direct or indirect patient care *Establishing criteria and standards of practice within the standard of practice of professional organizations, health care regulations, and federal and state requirements, as applicable to the institution; and	A 309	A309 Executive Responsibilities 482.21(e) The Mountain View Center for Geriatric psychiatry will ensure that its governing body, medical staff, and administrative officials are held responsible and accountable for ensuring that its QAPI program requirements are met. The Mountain View Center for Geriatric Psychiatry Hospital's QAPI program plan and policy has been reviewed, revised, and modified to reflect a QAPI program that is effective, ongoing, consistent, and hospital-wide as well as data driven. The newly revised QAPI plan and policy defines the role of the medical staff in relation to the QAPI program. Documentation in all QAPI meeting minutes will include the following: QAPI plans developed and approved by the board, including addressing the medical staff or the care that the medical staff provided to the patients; evidence that a peer review process to evaluate the appropriateness of diagnosis and care provided is in place. Meeting minutes will also include any specific actions taken based on data with instructions to monitor these data for specific purposes or specific levels of improvement in quality indicators.	1/11/08

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A 309	Continued From page 13 *Meeting with the Governing Board to discuss any problem areas encountered...The hospital administrator shall serve as the chairperson of the Quality Assurance Committee." The policy did not define the role of the medical staff in relation to QAPI. 2. Three "Hospital Governing Board Meeting" minutes for 2007 were provided to surveyors. These were dated 2/19/07, 5/1/07, and 8/7/07. Each set of minutes contained a report from the Medical Director, Administrator, and the DON stating what had been happening at the hospital. Each set of minutes also contained reports from various hospital departments including a minimal amount of QAPI information. For example, in the February minutes, the DON report listed items such as "Policy and procedures need to be reviewed and updated as necessary." and "Incidents and accidents have had a decline. This is probably due to low census and staff stability." Department reports for February were listed. The Dietary Report stated "Overall score 92% significant improvement over the 48% for last quarter." The "Social Service Report stated "The department has met the 95% threshold." In May, there was no DON report. The Dietary Report stated "Documentation decreased from 88% to 61%. This area will continue to be reviewed because the threshold was not met." The "Social Service Report stated "The department has met the 95% threshold. Social service will continue to meet the 95% threshold." In August, the DON report mentioned care plan updates, staff changes, and changes in the smoking schedule. The Dietary Report stated documentation had increased to 85%. Social Service decreased to 93%. From the minutes in	A 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 309	Continued From page 14 2007, no recommendations were documented from the Governing Board to any hospital department in response to the QAPI report. The Administrator was interviewed by telephone on 12/14/07 at 11:30 AM. The Administrator stated she had attended all of the Governing Board Meetings in 2007. She said the board discussed the QAPI reports but did not always document actions that were taken. She reviewed the minutes and stated she could not cite an instance where the board had taken specific action based on quality improvement data in 2007. In addition, she confirmed no QAPI plan had been developed and approved by the board. Governing Board meeting minutes did not address a QAPI plan. 4. The QAPI program was not hospital wide. The program did not address the medical staff or the care of the medical staff that was provided to patients. No peer review process or other system to evaluate the appropriateness of diagnosis and care provided was in place at the hospital. This was confirmed by the Medical Director on 12/6/07 at 1:25 PM. He stated no peer review or other process to assess medical care had been conducted in approximately two years. The Board minutes for February stated "There is a need for an independent peer review MD to review charts." This had not been developed. 5. Four Medical Executive Committee meetings were documented in 2007, on 2/13/07, 4/24/07, 7/24/07, and on 10/23/07. The minutes of these meetings contained reports from 14 different departments and areas. Data documented in the reports included the number of medication errors with a breakdown by type of error, percentages of the category audits and whether or not they met the 95% threshold, and statistics related to	A 309		

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A 309	Continued From page 15 admissions, discharges, and census. Documented recommendations and actions were general statements such as implement corrective actions, educate staff, continue chart analysis, and continue to report. No specific actions based on data with instructions to monitor data for specific purposes or specific levels of improvement in quality indicators were documented in the minutes. This was confirmed by the Medical Director on 12/6/07 at 1:25 PM. He stated the only QAPI issues discussed at the Medical executive meetings were related to utilization review.	A 309		

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B 000	16.03.14 Initial Comments The following deficiency was cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patricia O'Hara. RN, HFS Acronyms used in this report include: DON = Director of Nursing QA = Quality Assurance QAPI = Quality Assessment/Performance Improvement	B 000		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on review of hospital policies and quality improvement data and staff interview, it was determined the hospital failed to ensure that there was an effective, hospital-wide quality assurance program to evaluate the provision of care. The findings include: Refer to A0263 as it relates to the lack of a data driven QA program.	BB124	BB124 16.03.14.200.10 The hospital has developed a hospital-wide data driven Quality Assessment and Performance Improvement program which includes measureable goals to improve health outcomes, analysis of data, tracking of quality indicators, including the setting of priorities for performance improvement activities that focus on high-risk, high-volume, or problem prone areas. The hospital Governing Body has ensured that the QAPI program plan and policy developed reflects the complexity of the hospital's organization and services and is focused on indicators related to the improvement of health outcomes and the prevention and reduction of medical errors.	1/11/08

Bureau of Facility Standards

Donna Robinson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 1/14/08

IDAHO DEPARTMENT OF
HEALTH & WELFARE

FILE COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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January 22, 2008

Donna Robinson
Mountain View Center For Geriatric Psychiatry
500 Polk Street East
Kimberly, Idaho 83341

Dear Ms. Robinson:

On **December 7, 2007**, a Complaint Investigation was conducted at Mountain View Center For Geriatric Psychiatry. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003210

Allegation #1: A patient was accidentally knocked down by a CNA.

Findings: On 12/5-12/7/07 an unannounced visit was made to the facility. The patient's closed record was reviewed as were five additional records of patients with falls. Incident reports for the last 6 months were reviewed and staff were interviewed. One medical record documented an accident on 5/8/07 at 9:30 PM. A patient was in a common hallway returning from an outside cigarette break. At the same time, a Behavioral Health Technician was attempting to remove a second patient from a room that was off limits. The second patient was being uncooperative and pushed the Behavioral Health Technician. The BHT stumbled backward, bumping into the first patient, causing her to fall into a door jamb and then to the floor. The record stated that the patient struck her left arm on the door jamb and struck her right knee and the right side of her head on the floor. The patient was examined by the hospital staff for injury. The patient complained of left upper arm pain. Nursing documentation stated the patient's left upper arm was red. An ice bag was applied. The patient's right knee had bruising and swelling. The patient did not complain of head pain. The patient was assisted to a standing position and vital signs and neurological checks were initiated. These checks were continued until 1:00 A.M. The patient retired for the night at approximately 11:00 P.M.

Vital signs and neurological check results remained within normal limits. Further nursing documentation stated that the patient rested for seven hours with no further complaint of pain. Nursing notes stated that the following morning, the patient got out of bed and walked to the nurses' station at approximately 7:00 A.M. At that time the patient's right knee was noted to be red and swollen with a small purple bruise. The patient's left upper arm was red and tender to touch and the patient said she could not bend her left elbow and reported sharp pain in her left forearm. It was documented that the patient had two 3cm. bruises on the posterior left arm. A soft sling was applied but the patient took it off. The patient was transported to the hospital for X-rays of her left shoulder and arm. These were negative for any abnormality of bone or soft tissue. She was provided with pain medication by the facility physician on 5/9/07, at her request. On 5/10/07 the patient was taken to her primary care provider for examination. No further treatment was ordered. Nursing documentation on 5/10/07 at 9:00 P.M. stated that the patient denied pain.

Incident reports for a six month period of time were reviewed. These showed a low number of falls and minimal injuries. Appropriate actions, treatment and follow up were evident. This particular incident was an untimely accident. No deficiencies were cited related to the fall. However, it it was determined the hospital failed to measure, analyze, and track quality indicators, including falls and other adverse patient events, and other aspects of performance that assess processes of care. Deficiencies were cited at 42 CFR Part 482.21 Condition of Participation for Quality Assessment/Performance Improvement.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: A patient complained that specifically named hospital staff were very demeaning to her and made fun of her.

Findings: On 12/5-12/7/07 an unannounced visit was made to the facility. Staff schedules were reviewed, the patient's closed record was reviewed and staff was interviewed. The hospital staff specifically named by the patient were not found on the staff scheduling sheets during the time that the patient was at the facility. The Director of Nursing was interviewed on 12/6/07 at 1:00 P.M. She stated that no employees specifically named by the patient had been employed at the facility. She also stated that she was unaware of instances of derogatory comments directed at patients by staff members. Review of the patient's closed record did not show that the patient had reported an instance of verbal abuse during her stay at the facility. Further, there were no incident reports about verbal abuse of a patient from May 1, 2007 through 12/5/07.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw